Benefit Change Q&A for Changes in TennCare Medicaid

What services will no longer be covered?

For adults 21 or older who are in a TennCare Medicaid eligibility category, TennCare will NOT cover the following services after August 1, 2005:

- Medicine that can be purchased over the counter. Exception: Prenatal vitamins
- Dental care services
- Sitter services
- Convalescent care
- Payments to hold an unused bed in a nursing home while the enrollee is in the hospital or out of the nursing home for any reason
- Methadone clinic services

Medicaid Adults Age 21 and Older:

Who are receiving TennCare reimbursed long-term care will continue to have prescription drug coverage as medically necessary with no quantity limits and no co-pays until their eligibility ends (i.e., they are disenrolled).

What benefit limits are going into place?

Only the pharmacy benefit limit goes into effect at this time. That limit will begin on August 1.
A five (5) prescription limit per month on prescription drugs and refills
a. Of these 5 prescriptions per month, only two (2) can be brand name drugs. At least three (3) must be generic.
b. The prescription limit is counted monthly, beginning on the first day of each month.

Do these changes apply to everyone remaining on the program?

No.

- Medicaid Children under age 21 are not affected by August 1 benefit changes.
- None of the pharmacy changes (elimination of pharmacy coverage, prescription drug limits and co-pays) will affect enrollees who are receiving nursing home care or other long term care that TennCare pays for as long as they continue to be eligible for TennCare.
- If someone believes they have received a benefit change notice in error, the person should be directed to the Family Assistance Service Center at 1-866-311-4287.

When does all this happen?

The notices that mailed on July 1 tell enrollees about the changes that will go into place on August 1, 2005.

How do I know whether a drug is a brand name or a generic?

Ask the doctor who writes the prescription or the pharmacist who fills the prescription. Either one of these people will be able to tell you whether a drug is a brand name or a generic. You can ask your doctor to order generic drugs. A prescription for a brand name can be filled with a generic (as long as there's one available) unless your physician checks the "dispense as written" box on the prescription.

If I take more than 5 drugs each month, how do I know which 5 prescriptions will be paid for by TennCare?

TennCare will pay for the first five prescriptions that are submitted for payment each month as long as no more than two of those prescriptions are for brand name drugs. TennCare will begin counting again at the beginning of each month.

Can I get more than 3 generic drugs?

TennCare will pay for up to 5 generic drugs if no brand name drugs are used in any one month period.

Does that mean I don't have to pay for any generics—even if I get more than 5 prescriptions per month?

The member will be responsible for the **full cost** of generic and brand name drugs over the monthly limit. If a generic drug is covered, there will be no co-pay for that drug.

How do I know whether the drugs I'm taking will be paid for by TennCare?

Ask the doctor who writes the prescription or the pharmacist who fills your prescriptions. Either one of these two people will be able to tell you.

What can I do if I need more than 5 prescriptions per month? What about the short list?

There is a "Pharmacy Short List," which includes drugs that do not count against the limit. Eligible enrollees can receive these drugs even after the prescription limit has been reached in a single month. If a drug on the Pharmacy Short List is a brand name drug, the member must pay the $3 co-pay. This list is only for persons with a pharmacy limit. Persons with no pharmacy coverage will **not** be able to get drugs on the Pharmacy Short List paid by TennCare.

How can I get a copy of the pharmacy short list?

A listing of these drugs can be found at: http://www.tennessee.gov/tenncare/pharmacy/pdlinfo.htm. You can also call the DHS Family Assistance Service Center at 1-866-311-4287 to request a copy by mail.

Benefit Change Q&A for Changes in TennCare Standard

What services will no longer be covered?

For adults 21 or older who are in a TennCare Standard eligibility category, TennCare will NOT cover the following services after August 1, 2005:

- Medicine that can be purchased over the counter. Exception: Prenatal vitamins
- Dental care services
- Sitter services
- Convalescent care
- Payments to hold an unused bed in a nursing home while the enrollee is in the hospital or out of the nursing home for any reason
- Methadone clinic services
- Pharmacy Benefits

Do these changes apply to everyone remaining on the program?

The only change for children is a *reduction* in pharmacy co-pays for children under age 21 in TennCare Standard with incomes at or above the federal poverty level. Rather than a $5 or $10 co-pay for each prescription (including generic), they will pay $3 for brand name drugs only.

What about the other benefit limits? When will they begin?

Benefit limits other than the pharmacy limit will not be put in place until later this year. The only limit going into place right now is the monthly limit on prescription drugs for most adults age 21 and older on TennCare Medicaid.

What cost sharing/co-payments are going into place?

For Medicaid adults who have a pharmacy limit and for TennCare Standard enrollees up to age 21 with incomes at or above the federal poverty level, a $3 co-payment will be charged by your pharmacist for each brand name drug used. There is no co-payment for prescriptions for generic drugs. In addition, this co-payment will NOT apply to:

a. Birth control
b. Hospice care medications
c. Drugs for emergency situations
d. Pregnancy-related medications

Again, none of these benefit changes take place until August 1.